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The case against 'aging in place'

The author, an architect, proposes design criteria for a more aging-resident-friendly level of care

I don't like to move. It seems as though a lot of people I know don't like to move, either. Packing, leaving behind a familiar place, dismantling years of memories to start over again—it's a painful process even for those in the best of health. For those who are older and perhaps in need of some assistance, the situation can be especially traumatic and fraught with apprehension.

In CCRCs across the country, more and more residents are resisting the move to a more intensive level of care. This leads to "aging in place," and that can be a problem.

As time passes and their health begins to deteriorate, residents begin needing day-to-day assistance—help with laundry, meals, bathing, dressing, or other activities of daily living. Other developing problems might include lack of personal mobility, difficulty driving, and/or the onset of early stages of dementia. The loss of a spouse, a devastating event at any stage of life, can take on added significance when the deceased was responsible for a good deal of the surviving spouse's care.

For CCRC residents who are completely aware of their surroundings but just might need some physical assistance, the "medical model" environments (i.e., based on a typical hospital floor) of assisted living and skilled nursing were and remain places to be avoided at all costs. Subsequently, many residents suffer through long periods occupying an independent living unit with reduced capacity, declining health, dwindling social contact, increased depression, and other problems. While caregivers can visit the home or unit to provide assistance, and residents have the media to keep them abreast of day-to-day events, the situation becomes one of increasing dependency and inefficient, costly care. Many of these residents decline quite rapidly and often go straight to a skilled nursing facility, although the right program and environment for them might have prolonged their independence.

One of our goals, therefore, should be to provide accommodations that allow a resident or couple to move from a large independent living unit to a place that, while smaller and more easily staffed, is large enough and has the right mix of amenities to be an acceptable option. While it is true that many CCRCs allow their cottage residents to move into their independent living apartments as they require more care, and this is better than aging in place in a detached cottage, the caregiving situation remains difficult. These larger apartments, in some cases well over 1,500 square feet, can be as much as 60 feet from front door to front door and far away from dining and activity spaces. These distances, because of the mobility challenges they pose, make caregiving inefficient and socialization difficult. Moreover, these intracommunity independent living moves can delay or prevent new residents from coming into these communities.

What is the answer then? What can we provide that promotes independence, good health, and community; is efficient for staff; is attractive to residents and their families; and meets their needs?

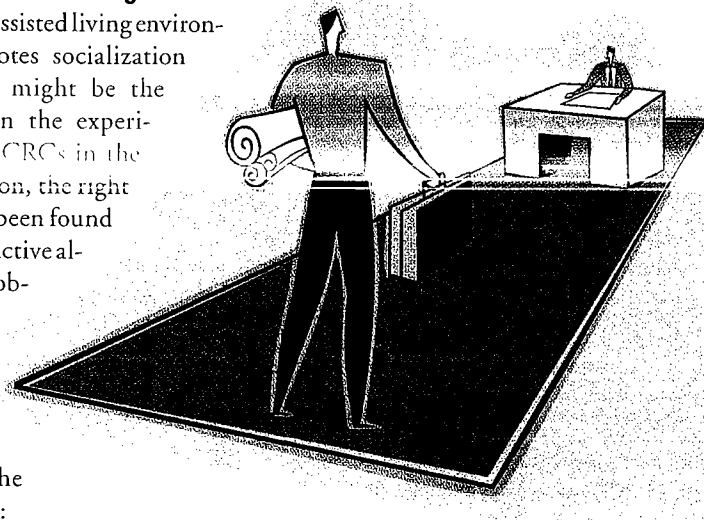
Social Model Assisted Living

A "social model" assisted living environment that promotes socialization and community might be the answer. Based on the experience of several CCRCs in the mid-Atlantic region, the right environment has been found to provide an attractive alternative to the problems associated with "aging in place" in the wrong place. Such a facility might include the following features:

- short travel distances from resident units to dining and other amenity spaces;
- a household-type arrangement involving a limited number of residents and with rooms opening directly into common spaces;
- larger individual units—ideally two-room minimum size apartments;
- food storage and preparation space in resident units;
- fewer units per floor (in larger facilities);
- residential character and ambience; and
- adequate storage space in each resident unit and throughout the building.

Other features that make social-model assisted living more appealing include:

- access to independent living common spaces and wellness services;
- convenient parking and transportation; and
- technologic conveniences and service features, such as a computer with Internet access as a standard feature in each unit, unobtrusive resident monitoring devices that allow staff to track mobility, activities, and sleep patterns, etc.



Some further explanation: In a household-style facility of 8 to 12 units, a large, single room with a private bathroom and shower may suffice—especially when common spaces and other amenities are directly outside residents' doors, in an arrangement similar to their homes. If a household model is inappropriate, large studios or preferably two-room apartments with a small kitchen or

kitchenette should be provided. The rooms should have a minimum dimension of 12 feet, in part because the larger rooms allow residents to furnish their apartments with their own furniture. To maximize space, consideration should be given during the design process to how possible furniture layouts will work with door swings, circulation paths, etc. A higher ceiling (9 feet or more)

in the living areas and large windows both contribute to an increased sense of space.

Since a resident in social-model assisted living will typically have three meals a day provided, the kitchen can be a small, independent space or one with a strip counter. The small kitchen might have smaller appliances and possibly an eat-in area, while a kitchenette may include a sink, under-counter refrigerator, and microwave (in some cases small ranges have been provided). For refrigerators, especially under-counter units, frost-free, zero-degree freezers are recommended. The zero-degree freezer allows for the storage of ice cream.

Given the downsizing that residents are doing to move into their new apartments, careful consideration should be given to resident storage space. Ideally, each apartment should have a walk-in closet. Remote storage often is also provided; this, preferably, would be on the same floor as the resident's unit but may be in a basement or other nearby area. Four-by-four by eight-foot-high storage cubicles, or similar sized lockable cages, are usually adequate.

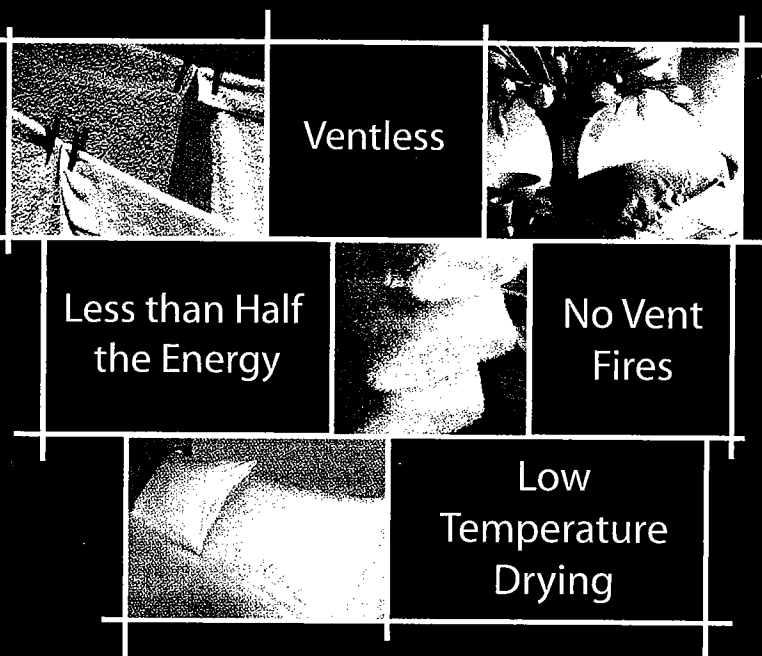
Provisions for housekeeping items, linens, equipment, medications, etc., should be considered when designing a social-model assisted living facility. Although their size and location are sometimes dictated by local regulations, these spaces correctly interspersed throughout a wing can cut down on travel times and increase staff efficiency.

Although resident laundry is typically done by staff in many CCRCs, a centrally located laundry room accessible to residents will sometimes be provided. This allows family or those more able and willing to do their own laundry to do so, if they wish.

Dining and Activity Spaces

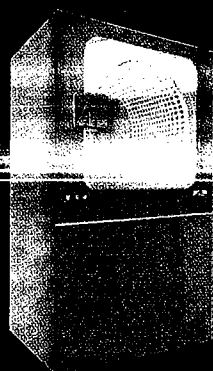
Although a social-model assisted living resident should be ambulatory, the reality is that it may be difficult for many residents to go very far without assistance. Therefore, it is important that services be brought to them. Several CCRCs in the mid-Atlantic region have found that these services should be within 80 to 100 feet of the resident's apartment, if possible. In larger facilities with multiple units, it may be better to go to multiple floors, especially if land is at a premium. Ideally the same amenities are provided on each floor. When space, cost, or other considerations make common areas impractical for each floor, the elevator can be a great mobility device that

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can allow dining and other amenity spaces to be interspersed among floors. Larger elevators are preferable. Those large enough to hold a stretcher will also hold a resident mobility cart and make move-ins easier. In multistory buildings, two elevators should be considered to allow for alternating maintenance. Also consider putting at least one of the elevators on emergency power.

Travel Distances

Travel distances affect not only residents, but also staff efficiency and performance. Smaller units having shorter travel distances between entrances reduce staff travel time, especially in going back and forth for supplies. Interspersing staff service areas around a floor and providing duplicate services on multiple floors also help improve staff effectiveness.

Along with shorter travel distances, provisions should be made for motorized carts. This includes providing space outside dining and other gathering areas to park and recharge the carts. Wider corridors and/or apartment foyers should also be considered for parking space at a resident's unit.

Fewer Units per Floor

Because fewer units per floor can mean shorter corridors to amenities, the shorter travel distances can translate into better care and services for residents. Staff can move more quickly between units and be available to assist more residents during a given shift. Building taller instead of wider also means using less land for the building footprint, which in turn preserves what for many communities is one of their most valuable resources—land. Of course, the total number of stories must also be considered in relation to per-floor staffing requirements and costs.

Residential Character, Ambience, and Furnishings

Social-model assisted living should be thought of as a resident's home first and a place to receive care second. Toward this end the architecture, finishes, and furnishings should resemble those of a nice apartment building or hotel, rather than a medical facility.

Proper selection of light fixtures, hardware, plumbing fixtures, etc., can contribute to the residential feel of a facility. Furniture in public spaces should reinforce this character. Many fabrics today can withstand stains and yet avoid an institutional feel.

Carpeting, ideally without a pad to prevent tripping, should be considered for corridors, dining rooms, and lounge spaces. It reduces noise and glare in corridors. Again, many products are available that resist stains and can be used for these high-traffic applications. Loop pile or loop-and-cut pile combinations should be considered, since they tend not to show wear tracks from cart

and other wheels quite as readily as other carpet surfaces. Vinyl and other materials are now available with a simulated wood appearance and may provide an alternative when carpeting is inappropriate.

Dining room chairs can present problems for more frail residents if not carefully chosen. A sturdy wooden frame or similar type chair with an upholstered back and seat and, most

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importantly, arms for added support should be considered. Casters are recommended if the chairs are heavier. When casters are planned, consider on which legs of the chair they should be installed: all four legs, the front legs, or the rear legs. Although this partially depends on the design of the casters themselves, if installed on all four legs, too much movement and increased danger of falls can result. Casters on both front legs or both rear legs is recommended. With casters installed on the front, the resident can lightly lift the rear of the chair and easily pull it back from the table. However, since each community is different, it may be appropriate to try both options before making a selection.

Access to a Community Center

Sometimes in a retirement community "us" versus "them" mentality exists among residents having different capabilities. Independent living residents often prefer to keep more frail residents out of sight. Even though this might be an issue for independent living residents and sometimes marketing, consideration should be given to how social-model assisted living residents might access amenities not provided on their wing. Where and how do residents go to worship, attend a musical performance, go for a swim, or perhaps relax at the community café? These are just a few of the questions that should be addressed during the programming and design process for social-model assisted living.

Access to the Outdoors

Correct porch design and placement can allow residents to passively participate in outdoor community events, both formal and informal—a garden party, nature-watching, etc. The porch's size and orientation, and whether it is screened, are issues to consider in light of a community's unique characteristics and environment.

Parking and Transportation

By the time people move to a social-model assisted living facility, they often have difficulty driving or might not have a driver's license anymore. For those who can still safely drive, though, some nearby parking is suggested. Although often directed by local regulation, one space for every six residents has been a good rule of thumb. Additional parking should also be provided for staff and visitors.

A regular shuttle service should be considered to take residents to medical appointments, local grocery stores, shops and other destinations. Lobby seating with good visibility is also recommended to allow residents to safely wait for rides. A covered pickup and drop-off area with direct, barrier-free access to the interior should also be provided.

Elevation Changes

If possible, the facility should have no stairs, other than those required for emergency egress. If a slight level change is necessary, a ramp can be used, but be careful: While the Americans With Disabilities Act requires a minimum ramp slope of 1 in 12, that can prove too steep for many residents—especially those in wheelchairs. Consider a 1 in 16 or lower slope, if space allows.

In trying to maintain the residential character of a facility, handrails may seem antithetical. However, many residents can use the added assistance. It is recommended that handrails be installed on at least one corridor wall. These can be designed to match the overall décor of the facility—in fact, handrails can be beautifully detailed. Sometimes a built-up, multipiece wood molding can be used as a leaning rail in lieu of a handrail.

Conclusion

Because dependency levels vary from population to population, the social-model assisted living facility may not be right for all communities. For some, it may be one component of a multilevel care program that includes assisted living dementia care, home healthcare, etc. However, for many CCRCs and other senior communities, it may assist in facilitating a resident's move through the continuum of care with minimal trauma and ultimately the best care that can be provided for the resident's current needs. It may prolong independence, postpone dependency, and maximize the resident's quality of life for as long as possible. ■

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